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[1]Department of Upper GI Surgery, Royal Wolverhampton NHS Trust, West Midlands, UK [2]Department of Anaesthesia, Royal Wolverhampton NHS Trust, West MIdlands, UK

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Burton Hospital, Burton upon Trent, UK

A1 Influence Of Patient And Surgeon Related Factors On Length Of Stay After Hemithyroidectomy

Muhammad Umair Rashid, Wael Elsaify

The James Cook University Hospital, South Tees NHS Foundation Trust, Middlesbrough, UK

Objectives: A consensus of British Association of Endocrine and Thyroid Surgeons suggested the feasibility of thyroid surgery as a day case. Our intentions were to find the effects of age of patients, ASA grade, weight of gland and operating time on postoperative length of stay.

Method: We collected retrospective data of patients who underwent hemithyroidectomy as a day case from Feb, 2013 to Feb, 2015. Age of patients, operating time, ASA grade and gland weight were analyzed against postoperative length of stay. The data was analysed using SPSS including correlation coefficients and scatter plots.

Results: A total of 76 patients (67 Female and 9 Male) underwent hemithyroidectomy who were deemed fit for day surgery during that time. Mean age was 47.17 with 15.10 SD. Mean operating time was 62.93 minutes with 15.09 SD. Mean postoperative length of stay was 18.14 hours with 2.33 SD. Mean postoperative length of stay was slightly shorter in ASA 3, 17.25 hours, compared to 18.24 and 18.16 hours for ASA 1 and 2 respectively. There was no readmission for any complication. The correlation between weight of the gland and postoperative length of stay was -0.123 and it is very weak negative. There was very weak negative correlation between operating time and length of stay with correlation coefficient of -0.092. When compared between age and postoperative length of stay, there was very weak positive correlation with correlation coefficient of 0.102. The scatter plots are a reflection of these results.

Conclusion: Hemithyroidectomy can be safely performed as a day case. Age of the patient, ASA grade, weight of gland and operating time do not contribute towards postoperative length of hospital stay.

Reference:

HE Doran, J England, and F Palazzo, Questionable safety of thyroid surgery with same day discharge. *Ann R Coll Surg Engl.* 2012 Nov; 94(8): 543–547.

A2 Length Of Stay After Simple Mastectomy: A Re-Audit

Francesca Muscara, Nichola Roche, Anjalina Majumder

The Royal Marsden Hospital, London, UK

Objectives: Day case (DC) breast non-reconstructive surgery is a priority in order to improve effectiveness by reducing unnecessary length of stay (LoS).1,2,3 A recent audit, between 10/2013-01/2014, showed that median LoS for simple mastectomy (SMx) was 50.31 hours and recommended better intra- and post-operative pain control and less use of drains.

The aim of this re-audit is to identify the potential factors leading to prolonged LoS for SMx and to demonstrate the role of anaesthetic considerations in enhancing patient's recovery and implementation of a successful scheme.

Method: 35 cases of SMx with/without axillary procedure, between 10/2014-01/2015, were included. Bilateral and private cases were excluded (n=17). The data collection was done retrospectively from prospectively recorded electronic records.

Results: Median age was 65.3 years. Median LoS was 40.12 hours, with a DC rate of 34% (vs 16% previous audit). At univariate analysis, age above 70, BMI and ASA 3 were found to be pre-operative predictors of prolonged LoS. Intraoperative use of drains, more extensive surgery on axilla and use of >2mcg/kg of Fentanyl were associated with prolonged LoS.

Conclusion: Default DC booking for SMx may reduce LoS especially in patients above 70 years old, with normal BMI and controlled comorbidities. Patients for SMx should be first or early on the list, with attention to DC anaesthesia and multimodal analgesia.

References:

1. Department of Health NHS Cancer Reform Strategy (2007) www.dh.gov.uk
2. PbR – Best Practice Tariffs Breast Cancer Workshop, Monday 18th March 2012
3. Julia Lambert, Cancer Nursing Practice March 2014; 13(2):18–23

A3 A Successful Approach To Day-Case Surgery 15 Miles Away?

Jessica Chang, Mridul Dey, Alistair Sharpies, Muhammed Ayub Khan

University Hospital North Midlands, Stoke-on-Trent, UK

Objectives: It is the responsibility of all healthcare providers to work towards delivering a successful day-surgery service for our patients. Since February 2015 our trust has developed an off-site dedicated day-surgery unit. Nurse-led discharge is the standard; all patients requiring overnight admission require transfer to the main hospital site. We aimed to assess how successful our new unit was at delivering day-case surgery.

Method: All patients operated on between 01/02/15 and 31/10/15 were identified. Demographics and procedure details were collected for each patient. All patients requiring overnight admission were identified and indications for transfer documented.

Results: 768 adult cases were performed in the study period, including: 158 proctology cases, 245 cholecystectomies, 19 laparoscopies (staging/biopsy), 251 abdominal wall (179 inguinal) hernia repairs, 5 endoscopies and 90 miscellaneous cases ("lumps & bumps").

Age ranged from 18-91 years (median 51) with 359 females (46.7%). 6.9% underwent procedures under local anaesthetic (n=53). Patients were ASA I (38.3%), ASA II (49.9%), ASA III (4.8%) and ASA IV (0.1% n=1).

Cholecystectomy (OR 3.47, p=0.005) has a significantly higher risk of admission, whereas Hernia repair (OR 1.185, p=0.7067) and proctology procedures (OR 0.174, p=0.0.089) offer no increase in risk of overnight admission.

Overall day-case rate is 97.1% (national figures1 78.12%). Procedure specific day-case rates exceed national average; cholecystectomy (94.6% vs 52.17%), inguinal hernia (99.96% vs 70.82%), haemorrhoidectomy (100% versus 76.64%)

Conclusion: Our results show the success which may achieved with a dedicated day-case unit. The off-site nature of our unit relies heavily on a robust nurse-led discharge protocol and close liaison with operative surgeons. We feel our results stand as an indicator of what can be achieved with a good multidisciplinary approach to day-case surgery.

Reference:

1. NHS Better Care, Better Value Indicators "http://www.poductivity.nhs.uk"

A4 Oral Morphine Solution (OMS) In Day Surgery (DS)

Mohd Aizad Mohd Yusof, John Vernon

Nottingham University Hospitals NHS Trust City Campus, Nottingham, UK

Objectives: Day Surgery Recovery Analgesia (DSRA) typically includes paracetamol, NSAIDs, fentanyl, tramadol and codeine1. There are known issues with codeine, tramadol. Despite OMS appearing useful for DSRA, literature search on OMS for DSRA revealed paucity of experience/guidelines. Concerns with OMS include nausea, delayed sedation/respiratory depression following discharge.

Method: OMS has been widely used in NUH for 10 years. Trialling various regimens of OMS for DSRA in our unit led to development of our current regimen. Oral Ibuprofen and Paracetamol (I+P) are routinely given preop. Anaesthetist signs preprinted DSRA prescription for I+P, OMS, PONV, Intravenous (IV) rescue opioids, DS nurses use analgesia ladder to guide DSRA.

Patients are prescribed a Maximum Hourly Rolling Dose (MHRD) of OMS (typically 30mg). OMS doses should be given at least 30 minutes apart and must not exceed MHRD in any rolling 60-minute period. A total dose of 2xMHRD of OMS may be given for the full duration of patient stay in DS Unit. Patients receiving no IV morphine and ≤MHRD for OMS can be safely discharged 60 minutes following last dose, whilst patients receiving IV morphine with or without OMS >MHRD can be safely discharged 90 minutes following last dose.

Results: Our nurses have become skilled at titration of analgesia to effect, minimising side effects of OMS. This regime has been used for 5 years without reported adverse events. Informal staff/ patients survey reveals an unremarkable side effect profile. Pharmacokinetic/dynamic calculations of morphine and metabolites suggest it's safe to discharge patients 90 minutes following OMS or IV morphine2.

Conclusion: Our OMS regimen for DSRA appears to be safe and effective.

References:

1. Smith I, et al. *Day Case Surgery*. Oxford University Press 2011; 134–141.

2. Mazoit JX, et al. *Anesthesia Analgesia* 2007; 105.1: 70–8.

A5 Improving Our Nurse Led Discharge Protocol In A Busy District General Hospital: A Re-Audit

Susan Yeung[1], Kim Russon[2]

[1]Sheffield Teaching Hospitals NHS Trust, Sheffield, UK [2]Rotherham District General Hospital, Rotherham, UK

Objectives: Increasing numbers of patients are undergoing more complex procedures who are considered appropriate for day case surgery[1]. Protocol-driven, nurse-led discharge are fundamental to safe and effective day and short stay surgery[1]. Thus the timely discharge of these patients is usually delegated to day surgery nurses. The process of discharge planning should be nurse led as this minimises delays and uses staff most efficiently[2]. The RCoA recommend auditing discharge protocols for safe and effective discharge[3].

Our previous audit in March 2015, based on a RCoA audit recipe[3], identified queries about whether discharge criteria were being met. This was attributed to poor documentation by the nurses in the Day Surgery Unit (DSU) care plan.

Method: Our discharge criteria were updated based on BADS guidance[2] and the DSU care plan amended. In October 2015, we repeated the audit.

Results: Notes were reviewed on the day of surgery: 51 patients following General Anaesthesia (GA) or regional anaesthesia (RA), 18 patients following Local Anaesthesia (LA). Our re-audit results show our improved compliance on most of our discharge criteria both for GA or RA and LA. We achieved 100% compliance on numerous criteria as shown by Table 1.

Conclusion: We believe that our day surgery paperwork now reflects the discharge protocol by using a tick-box approach. This allows for quick, simple and clear documentation, as well as a reminder for the nurses. It is important to avoid overburdening DSU staff with paperwork in this busy high throughput environment. Redesigning our DSU paperwork has helped us demonstrate the safe discharge of our day surgery patients according to our discharge criteria.

References:

1. *Day Case and Short Stay Surgery*. AAGBI. May 2011.
2. *Nurse Led Discharge*. BADS. May 2009.
3. *Raising the standard: a compendium of audit recipes*. 3rd Edition. RCOA. 2012.

A6 Demographics And Airway Management Of Paraumbilical And Epigastric Hernias In Day Surgery

Rachel Tibble

Royal Derby Hospital, Derbyshire, UK

Objectives: Paraumbilical hernias should be day surgery operations. Anaesthetic management is influenced by BMI, difficult airways and acid reflux symptoms. NAP4[1] reviewed adverse airway events and aspiration and made recommendations to reduce these. We aimed to identify patient factors and airway management in our patients and relate this to NAP4.

Methods: 6 months paraumbilical/epigastric hernia repair data. BMI, difficult intubation predictors (previous difficult intubation), acid reflux symptoms identified and compared to population rates. Airway management in patients with risk factors from NAP4 noted.

Results:

- 60 patients.
- 43% BMI>30, 17% BMI >35 and 3.3% BMI >40.
- 33 patients (55%) - one or more difficult intubation predictors. 3(5%) documented grade 3 intubation, 7% grade 2.
- Acid reflux symptoms; 23 patients(38%).
- 35 (58%) patients had LMA, 11(18%) second generation LMA and 11(18%) intubated. 2 spinal anaesthesia and 1 endotracheal tube(ETT) then LMA.

Conclusions: Our patients had higher BMI than general population.[2]

- >30 kg/m^2 43% vs 24%,
- >35 kg/m^2, 17% vs 7%
- >40 kg/m^2 3.3% vs 2%.
- 5% grade 3 intubations but NAP4 suggests difficulty in 1% of the population.1
- 38% of patients had heartburn or acid reflux symptoms, compared to 28.7% UK prevalence[3], possibly related to higher BMI.
- NAP 4 Recommendation: If intubation not considered indicated, but concerns about regurgitation risk, second generation supraglottic airways are more logical choices than first generation ones.
- Our data shows BMI >35, 1 had a LMA, 3 second generation LMA , 5 ETTs. 1 spinal.
- With reflux symptoms 8 had LMA, 9 had 2nd generation LMA, 6 had ETTs.

Further education on NAP4 recommendations and second generation LMA availability in day surgery needed to fully implement safe surgery.

References:

1. *4th National Audit Project Royal College of Anaesthetists*. 2011
2. Baker,C House of Commons library briefing paper:3336; feb 2016
3. Kennedy T, *Aliment Ther Pharmacol* 2000; 14: 1589-94

A7 The Compliance Of Salford Royal Foundation Trust (SRFT) Current Discharge Guidelines With The Guideline Set By The British Association Of Day Surgery (BADS)

Nadir Ibrahim[1,2], Ming Wilson[2], Karim Zuberi[1], Nitesh Rathod[1]

[1]Manchester University, Manchester, UK, [2]Salford Royal Hospital, Manchester, UK

Objectives: With advances in medical care, day procedures have become the preferred method of surgery in the National Health Service (NHS). Appropriate discharge contributes to successful patient recovery. A combination of monitoring vital signs, informing patients about their post-operative care and analgesia come together to form current discharge protocols.

We aimed to assess how closely Salford Royal Foundation Trust (SRFT) follows current discharge guidelines set by the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the British Association of Day Surgery (BADS). Using data from a sample of patients, the efficacy of current discharge protocols were evaluated based on readmission rates.

Method: The electronic patient data of 436 individuals who had undergone day surgery in the specialities urology, neurology, orthopaedics, endoscopy and breast surgery between 1st September and 31st December 2015 were obtained. Adherence to discharge guidelines and rates of readmission were identified.

Results: Of the 436 patient electronic notes that were reviewed in the study, 325 (75%) contained scanned surgical discharge pathways. Of these 325, 11 patients were readmitted within 2 weeks (3.4%). 3 readmitted due to haematuria (0.9%), 3 due to post-operative pain (0,9%), 2 due to wound issues (0.6%), 1 due to post-operative breast haematoma (0.3%), 1 for blood tests (0.3%) and 1 due to nausea (0.3%).

Conclusions: Current discharge protocols at SRFT do not meet national levels of best practice. Areas for improvement have been highlighted.

References:

QRG16(15) – Issue No 1 - Discharge form Day Surgery Unit [pdf / 271KB] Review Date: May 2017 Issue No 1 Posted 23/11/2015

Nurse Led Discharge (BADS Handbook)

Section 5: Day surgery services File Format: PDF/Adobe Acrobat Patient information for day surgery. 5.2. Pre-admission assessment. 5.3. Adequacy of post-operative pain relief after discharge. 5.4. Day surgery theatre ... www.rcoa.ac.uk https://www.rcoa.ac.uk/system/files/CSQ-ARB2012-SEC5.pdf clipped from Google - 3/2016

A8 Preoperative Fluids Policy: Time For A Change?

Graham McCracken, Jane Montgomery

Torbay and South Devon NHS Foundation Trust, Torquay, Devon, UK

Objectives: Preoperative starvation guidelines generally recommend withholding clear fluids for 2 hours prior to surgery. Prolonged starvation can lead to postoperative complications and in SNAP-1 the most frequently complained of severe symptom was thirst[1]. It can be difficult to predict the timing of surgery even on an elective list. In Torbay Hospital, a pragmatic approach to preoperative fluids was adopted in October 2014. Knowing the relatively short half life of water in the stomach[2] patients are permitted to drink sips of water freely until called to theatre.

Method: Over a two week period from February to March 2016, we conducted a satisfaction survey of day surgery patients using a questionnaire adapted from that used for SNAP- 1 in May 2014, against which results were compared.

Results: The results demonstrated a reduction in the number of patients experiencing severe thirst (7/78 [0.09] in 2016 vs. 11/69 [0.16] in 2014; RR 0.56) Additionally, a reduction in the rate of mild or severe nausea and vomiting was observed (9/80 [0.11] vs. 11/68 [0.16] ; RR 0.70). Since the introduction of our more liberal fluid policy there has been no patient who has suffered aspiration of gastric contents in theatre that has required transfer to a higher level of care.

Conclusion: Although not statistically significant, the findings point to a positive trend in patient centred outcomes that require further investigation.

References:

1. Ramani Moonesinghe; Personal Communication; 2016.
2. Bateman B. N., Whitingham T. A.; Measurement of gastric emptying by real-time ultrasound; *Gut*; 1982; 23; 524–527.

A9 Use Of Day Surgery Facilities For In-Patients During Escalation- Our Experience In Norwich

Kate Booth, Helen Ball, Anna Lipp

Arthur South Day Procedure Unit ,Norfolk and Norwich University Hospital, Norwich, UK

Objectives: In many hospitals day surgery facilities are used to accommodate in-patients with a significant impact on the quality and quantity of day surgery provided. This is our experience of our day procedure unit(DPU) being used to accommodate in-patients during 2015-16.

A trust wide escalation policy enabled opening of DPU overnight to accommodate suitably selected "step-down" patients and DPU was opened overnight from December to March. The challenges we faced related to:

- Increased number of in- patients plus day case surgery patients with no additional staff
- Patient selection not matching selection criteria
- No facility for showers, natural light and access to entertainment
- Medical teams unaware of patients being moved and slow to review them
- Lack of security

Results:

- Complaints increased and incident reports doubled.
- Internal Quality audit identified inadequate care for in patients
- Staff raised concerns about poor quality of care and increased stress levels at work
- Changes were made to working practices:
- Senior day surgery staff attended daily trust-wide operational meeting
- Monthly review of incidents and complaints identified new problems resulting from extra pressures such as inappropriate patient selection and failure to provide expected standard day surgery care such as telephone advice after discharge.
- Reporting systems simplified to ensure staff under pressure can also report problems
- Patient information amended to ensure patients aware of restrictions of escalation area
- Provision of additional food and drinks services

Conclusion: Day surgery facilities provide an unsuitable environment for in patients and their use for in-patients may result in increase in complaints and incidents and stress to staff. Design of a day surgery unit to discourage inpatient use may not prevent its use when pressure for in-patient beds is severe. However careful wording and application of an escalation policy may help ensure safe use of day case facilities for in patients.

A10 How Does Day Case Laparoscopic Cholecystectomy Sit Within The Whole Elective Cholecystectomy Service? A 5 Year Study

Michael Stechman, Richard Whiston

Cardiff & Vale UHB, Cardiff, UK

Objectives: To evaluate the current position of day case cholecystectomy within a single health board and identify possible areas of improvement.

Method: All cholecystectomies performed between Jan 2010 and Dec 2014 were identified from the theatre management database and each record was examined through the local clinical portal system. Patients undergoing cholecystectomy as part of another procedure e.g. Liver surgery were excluded.

Results: 2085 patients (1634 female, 451 male; median age 50, range 15-91) had a cholecystectomy performed in the 5 year period. 60 patients had planned open cholecystectomies with the remainder (97.1%) having an intention to treat with laparoscopic surgery of which there was a conversion rate of 4.1%.

Laparoscopic surgery was performed in 3 settings; a day surgery unit (DSU), a short stay unit (SSU; 23hr 59min) and in-patient wards (IP). 1424 were treated in DSU with a 2.8% conversion rate and a 73.2% day case rate compared with 263 in SSU with 3% conversion and 32% day case rate and 325 IP with a 10.1% conversion rate and 1.2% day case rate. Overall 30 day readmission rate was 5.2% and 30 day mortality was 0.14%

Conclusion: Laparoscopic cholecystectomy can be performed safely and effectively as a day case procedure in the majority of patients. The setting of where surgery performed influences day case rates and there is scope in our health board to improve our results by treating more patients through the DSU.

A11 What Is The Incidence Of Venous Thromboembolism After Varicose Vein Surgery Performed Under Local Anaesthesia?

Ayoola Awopetu, Sam Gilbertson, Phil Bennett, Elizabeth Lorie, Nicola Korn, Anna Lipp

The Norfolk and Norwich University Hospital, Norwich, UK

Objectives: Surgery for symptomatic varicose veins is a common daycase operation. Many cases are now carried out as 'non-operative, uncomplicated' procedures with local anaesthesia (LA). NICE[1] recommends the use of low molecular weight heparin (LMWH) for surgery under general anaesthesia to reduce venous thromboembolism (VTE), but has made no recommendations for patients undergoing LA procedures. There is no published evidence about the incidence of VTE following 'uncomplicated' varicose vein surgery compared to surgery under general anaesthesia. Previous review of all cases of hospital-acquired thrombosis (HAT) presenting to Norfolk and Norwich University Hospital has demonstrated varicose vein surgery to be a major risk factor of VTE (prevalence of 1/100) compared to overall prevalence of 0.65% for all daycase surgery procedures[2].

Method: Root cause analysis was performed of all cases of HAT presenting to our trust within 90 days following varicose vein surgery over a five-year period. VTE cases were identified through outpatient VTE and inpatient anticoagulation services.

Results: 676 patients underwent varicose vein surgery during this time period. Six cases of HAT were identified (pulmonary embolism two; proximal deep vein thrombosis two, distal deep vein thrombosis two) with an overall incidence of 1 in 100. Three patients received a single dose of heparin and three received 5 days of LMWH. Two patients had history of thrombophlebitis and three had a personal or family history of VTE.

Conclusion: VTE following LA varicose vein surgery (<1 in 100) has the same incidence of HAT as that found after GA varicose vein surgery. We recommend the risks of VTE after LA varicose vein surgery are discussed with patients, and that post-operative LMWH is used for 5 days to reduce the risk of VTE.

References:

1. NICE. *Venous thromboembolism: reducing the risk* (CG92). London: NICE (2010)
2. Canciani et al. *JODS Abstracts supplement* 2015.

A12 Daycase TURBT – Are Quality Performance Indicators For Bladder Cancer Management Maintained In The Day Surgery Unit?

Natasha Szmidt, Stephanie Williams, Seamus MacDermott, Nicholas Campain

Torbay & South Devon NHS Foundation Trust, Torquay, UK

Objectives: TURBT (Transurethral resection of bladder tumour) is the gold standard initial treatment for bladder cancer, to remove all macroscopic tumour and obtain tissue for histological evaluation. Clinical quality performance indicators exist[1,2] for the management of bladder cancer and include; quality of resection (complete/incomplete, muscle sample in specimen) and administration of chemotherapy (Mitomycin C) within 24 hours of surgery. Quality performance indicators of daycase TURBT were evaluated.

Method: 45 patients (88% male) underwent first TURBT between June 2015 – Jan 2016. Average age was 72.4 yrs (37 – 96 yrs). Majority (78%) procedures were performed by Consultant Urologists. 25 patients (55%) had a daycase procedure.

Results: More patients (84%, 21/25) in the day surgery unit had a documented complete resection of tumour compared to inpatients (64%, 12/20). Rates of administration of chemotherapy (Mitomycin C) were similar between daycase and inpatients (68% vs 65%). Muscle sample present in histology specimens was lower for daycase patients (44% vs 90%).

Conclusion: Differences were observed for quality indicators between daycase and inpatient TURBT procedures. Lower rates of muscle sampling may be explained by case selection in the day surgery unit. Further process indicators (re-admission rates, recurrence at 6 months) will be presented. Long term patient outcomes for daycase TURBT require further evaluation.

References:

1. *Bladder Cancer; Diagnosis and management*, National Institute for Health and Care Excllence (NICE) NICE Guideline (NG)-002, February 2015.
2. Scottish Cancer Taskforce, National Cancer Quality Steering Group, *Bladder Cancer; Clinical Quality Performance Indicators* January 2014. Published by: Healthcare Improvement Scotland.

B1 Day-Case Ileostomy Reversal Is Feasible And Safe

James Blackwell[1,2], Oliver Peacock[1], Ashish Bhalla[1], Gillian Tierney[1], John Williams[1,2], Jonathon Lund[1,2]

[1]Royal Derby Hospital, Derby, Midlands, UK, [2]Nottingham University, Nottingham, Midlands, UK

Objectives: In the UK between January 2014-January 2015 there were 4806 ileostomy closures performed with median length of stay 5 days (36,526 bed days).[1] The authors aimed to develop a specific patient pathway for day case reversal of loop ileostomy.

Method: Previously we implemented a successful 23-h protocol for loop ileostomy closure which after proving feasible and safe was modified for same day discharge. The resulting specific patient pathway for day case discharge following loop ileostomy closure was implemented with inclusion criteria to conform with British Association of Day Surgery guidelines (BADS).[2] Exclusion criteria included post-operative chemo-radiotherapy, multiple comorbidities and social care needs. Patients were provided with a 24 hour point of surgical contact in case of emergency, were contacted by telephone at 24 and 72 hours post discharge and were given a routine outpatient appointment.

Results: Fifteen patients (12 male), median age 67 (39-80), underwent day case loop ileostomy reversal. All were discharged on the same day. There was one complication (UTI); no readmissions were required secondary to ileostomy reversal.

Conclusion: This pilot study demonstrates that day case reversal of ileostomy in patients who meet BADS guidelines is feasible and promises to save a significant number of bed days if rolled out.

References:

1. http://www.hscic.gov.uk/searchcatalogue?
2. Verma R, Alladi R, Jackson I et al (2011) Day case and short stay surgery: *Anaesthesia* 66:417–434.

B2 Learning From Patients – Clarity In Patient Information

Jan Roberts[1], Paula Le Poidevin[2], Carol Makin[2]

[1]Princess Elizabeth Hospital, St Andrews, Guernsey, [2]Medical Specialist Group, St Martin's, Guernsey

Objectives:

- To understand day patient service from the patient perspective.
- To improve patient information and advice.

Method: Review of responses to a generic hospital "How are we doing?" questionnaire suggested two immediate areas for improvement in our hospital.

1. Pre-operative information
2. Advice on post-operative wound care

A questionnaire specifically relating to wound care was devised and given to patients attending follow up clinic. A facilitated feedback session with patients and nursing staff.

Results:

- Most patients reported excellent care and that procedures went according to plan.
- Not every patient received existing information leaflets. However, some received conflicting information from multiple sources.
- Contact numbers were provided for wards, nursing staff and consultants without explanation of whom to contact in a given situation.
- Instructions to bring a dressing gown and slippers was redundant.
- Unnecessary information was given to patients undergoing local anaesthetic procedures.
- There was no advice on post operative analgesia prior to admission.
- Hospital supplied take home pre-packed analgesia was frequently inappropriate.
- Patients were confused by the variety of dressings used and requested a standard dressing.
- They suggested that post-operative information be given out with pre-operative information.

Conclusions: There are two separate parts to our provider service – hospital and doctors. Historically both have provided patient information covering the same topics. Joint leaflets have been designed, fixing the above problems and have been agreed by all parties. They are available to patients in print and on the hospital and doctors websites.

B3 An Audit Of Functional Ability And Need For Adult Support In The First 24 Hours Following Day Surgery

Thaamharah Mahendrayogam, Emad Fawzy, Benjamin Fox

Queen Elizabeth Hospital, Kings Lynn, Norfolk, UK

Objectives: Following most procedures under general anaesthesia a responsible adult should escort the patient home and provide support for 24 hours[1]. If a patient does not satisfy agreed discharge criteria[2] they may require overnight admission. Our audit aimed to determine if certain day surgery patients could be safely discharged home without an accompanying adult for 24 hours.

Method: Between May-July 2015 100 patients attending the Arthur Levin Day Surgery centre were given questionnaires in hospital-addressed envelopes to complete on discharge. The questionnaires enquired if assistance with activities of daily living (ADLs) (ie personal care, cleaning, cooking, driving) was required in the first 24 hours postoperatively. Written patient consent was obtained and confidentiality was maintained.

Results: 55 questionnaires received (55% response rate). 25 patients (45%) required assistance with ADLs: driving (21), cooking (19), cleaning (14) and personal care (9). One patient (TURBT) who did not have an accompanying adult for ≥24 hours required medical attention.

ADL assistance was required by 62% patients aged <55 years [compared with 26% >55 years] [statistically significant(X2 6.83, p 0.009)]. 52% ASA1, 44% ASA2 and 25% ASA3 patients also required assistance. A greater proportion of orthopaedic cases required assistance compared to non-orthopaedic cases (12 (75%) v 13 (33.3%); relative risk 2.25, 95% CI 1.33 - 3.089). Over 20% cases that did not require assistance appreciated it being there.

Conclusions: Orthopaedic day case procedures and younger patients appeared to require adult support 24 hours postoperatively which may reflect older patients being more stoic. The patient requiring medical attention following <24 hour observation is a learning point communicated to our unit. Postoperative (particularly orthopaedic) support should remain for 24 hours and arrangements for no assistance made on a case by case basis.

References:

1. *Day case and short stay surgery: 2. Anaesthesia* 2011; 66:417–434.
2. *Nurse led discharge*. London: BADS, 2009.

B4 Improving The Quality Of Post-Operative And Discharge Instructions After Day Case Breast Surgery: A Service Improvement Project

Gaël Nana, Hilary Brewer, Lisa Whisker

Nottingham Breast Institute, Nottingham, UK

Objectives: Surgical procedures for breast cancer are routinely performed as day case and short stay surgery. Clear discharge instructions, good quality advice leaflets and protocols are instrumental for safe nurse-led discharge and on-going patient guided management after surgery. This study assesses the impact of a check box style proforma on the quality of post-operative and discharge instructions.

Method: We retrospectively reviewed the surgical notes and discharge summaries for a sample of breast cancer patients undergoing day case and short stay surgery at a single centre between November 2015 and January 2016. Key outcomes including venous thrombo-embolism (VTE) assessment, drain management, antibiotic prophylaxis, follow-up appointments and discharge leaflet provision were recorded. A points system was used to rate the completeness. We trialled a standardised post-operative summary consisting of check boxes and re-assessed through re-audit.

Results: In the first cycle, 28 female patients underwent 34 operations including lumpectomy (17), mastectomy and axillary surgery (10) and immediate breast reconstruction (7). Planned overnight stay was associated with mastectomy and reconstruction (n=15patients). 86% (n=24patients) had clearly documented clinic follow-up plans. VTE and drain instructions were clear in 17.8% and 28.6% of patients' instructions respectively. 3 patients required antibiotics. Discharge leaflets were seldom mentioned in the post-operative notes (17.9%). The preliminary results from our second cycle, following the introduction of our post-operative proforma, show an improvement in VTE, drain and antibiotic instructions.

Conclusion: Patients have clearly documented clinic follow-up appointment plans. For those who stay overnight, the quality of the post-operative instructions can be improved. A simple check box style proforma improves the quality of key patient and outcome measures.

B5 Increasing Uptake Of 'One Stop' Preassessment Appointments – An Evaluation Of Patient Experience In A Day Surgery Unit

Sarah Shaw, Theresa Hinde, Mary Stocker

Torbay and South Devon NHS Foundation Trust, Torquay, Devon, UK

Objectives: Patients deemed fit for surgery should undergo their procedure within 18 weeks, as highlighted by the NHS Workforce Project, 20061. A 'one stop' preoperative assessment on the same day as surgical appointments helps to address this challenge. Our Day Surgery Unit (DSU) has a 60% uptake of 'one-stop' appointments. We aimed to identify patient experience of this service and strategies to further increase its uptake.

Method: A patient survey was conducted in the DSU to evaluate experience of the preoperative process. All patients attending for elective surgery were eligible to be included. Staff interviews were also conducted to establish their perspective of the 'patient journey'.

Results: Of the 38 patients interviewed, 13 (34.2%) had been seen via the one stop service. They gave positive feedback regarding the convenience of the experience. Of the 25 (65.8%) seen at a separate visit, 9 (36%) were unaware a one stop service was available, 6 (24%) reported no time/other commitments and a further 9 (36%) quoted 'other' reasons. 67% would have attended a one-stop clinic if offered.

Staff felt that patient satisfaction with the process and uptake of appointments was high.

Conclusions: Uptake of the 'one stop' service is good in our unit, however we have room for improvement. These results highlight that a proportion of patients are unaware that the service is on offer. We plan to implement the following changes.

- Alter the booking process for DSU preassessment appointments by ensuring patients attend the DSU reception in person to book their 'slot' immediately following the decision for surgery
- Ensure all surgical clinic appointment letters contain information about their option to attend a same day preoperative assessment service if they need surgery. We anticipate that this may improve uptake and thus efficiency and patient experience.

References:

1. Jackson A. *Nursing Management* 2009:15.9:24–27.

B6 Having Surgery, After Breast Cancer Surgery: The Introduction Of A New Policy

Caroline Kane, Mary Stocker

Torbay and South Devon NHS Foundation Trust, Torquay, Devon, UK

Objectives: For many years, patients who have undergone axillary lymph node surgery for breast cancer have been advised to avoid venepuncture, intravenous cannulation and blood pressure measurement on their ipsilateral arm, as a lifelong measure to prevent lymphoedema post-operatively.

This was based on hypotheses that infection was a precipitant of post-operative arm swelling in this group.[1] However, supporting evidence is poor[2] and there is a lack of clarity in the information provided. Weight gain is in fact the only factor reliably shown to increase risk.[1] Enforcement of this has been recognised as a source of anxiety for patients who attend for further surgery after breast cancer treatment, many of whom will present to our day surgery units.

We aim to present up-to-date evidence on this topic, and new guidance. We hope to dispel any myths around current information given, standardise practice & lessen anxiety for breast cancer patients.

Method: A literature review of the evidence was undertaken. New guidance was issued to staff at Torbay Hospital and an information leaflet was drafted and distributed to eligible patients presenting for surgery within the pre-assessment, day surgery and inpatient surgical departments.

An audit was undertaken to determine the number of patients affected, and their response to the information leaflet provided.

Results: Patient feedback has been positive, showing that our information leaflet given at pre-assessment or on the day of surgery was reassuring for patients who had undergone previous breast surgery and had previously been told to avoid procedures on their ipsilateral arm.

Conclusions: Current practice is outdated. Staff and patient education is required to produce change, reduce anxiety and avoid risk associated with inconsistent information-giving.

References:

1. Cemal Y et al. *J Am Coll Surg*, 2011; 213:543

2. Fulford D et al. *Ann R Coll Surg Engl*, 2010; 92:573

P2 A DGH Experience: Day Case Laparoscopic Sterilisation, Any Room For Improvement?

Ping Chen, Wasim Huda, Shilpa Pangam
West Suffolk Hospital, Bury St Edmunds, UK

Objectives: Laparoscopic sterilisation is a common surgical procedure carried out in day surgery unit (DSU). Post-operative analgesia is a very important factor to facilitate early discharge. RCoA suggests <2% unplanned admission rate should be considered.1 This project aims to find out current practice in DSU and identify any improvements that can be made.

Method: Retrospective computer-based search identified 53 patients underwent laparoscopic sterilisation using Filshie clips in DSU between January 2013 and March 2015. Case notes were analysed.

Results: All patients ASA grade 1-2. Intra-operatively, majority of patients received local anaesthetic. 47% and 53% of procedures carried out respectively in the morning and afternoon. There were total of 3 (5.66%) admissions, which 2 were from afternoon list. There were 4 patients returned to PACU from DSU ward area for further pain management. Post-operative average stays for the remaining 46 patients were 4.27 hours. Post-operative average requirement of fentanyl and oramorph were 50mcg and 26.8mg respectively. Procedure time have no correlation to recovery duration.

Conclusion: Pain following laparoscopic sterilisation can be severe and difficult to treat. Buscopan has no significant analgesia effect.2 Insufflation gas warming may have some benefits. Late afternoon arrival to recovery is an identified risk factor for admission. Application of bupivacaine directly to fallopian tube only demonstrated pain relief within 1 hour. However, use of ropivacaine may be more beneficial than bupivacaine.3 We aim to reduce the admission rate by refining our practice.

References:

1. M. Stocker, Unplanned admission after day surgery. Raising the Standard: a compendium of audit recipes. RoCA. 2012.
2. A. Habib et al. Buscopan for the treatment of pain after laparoscopic sterilisation. *Anaesthesia* 2001 Feb; 56(2):174–176.
3. A. Goldstein et al. Preventing postoperative pain by local anesthetic instillation after laparoscopic gynecologic surgery: a placebo-controlled comparison of bupivacaine and ropivacaine. *Anesth Analg*. 2000 Aug; 91(2):403–7.

P4 Gynaecological Day Case Operating – What Is An Acceptable Unplanned Admission Rate?

Guy Morris, Jane Farey
University Hospitals Bristol NHS Foundation Trust, Bristol, UK

Objectives: There is a national drive to perform 75% of elective surgery as day case. In our trust each unexpected admission to the ward overnight costs an additional £148. A review of the literature leads us to conclude there is no nationally accepted rate for unplanned admissions (UA) following gynaecological day case surgery. We have identified our UA rate following day case surgery and identified modifiable factors.

Method: A retrospective case note review of 170 patients undergoing day case surgery was performed. Patients with unplanned overnight admissions were identified from an 8 month period February - September 2015. Clinical notes review was undertaken to highlight common themes contributing to their unplanned admission.

Results: In this study there was an unplanned admission rate of 9.4% (16 out of 170 cases identified). Issues arising at the time of surgery accounted for the majority of the UA (12 out of the 16 cases) including: intraoperative bleeding (2 /12); conversion to laparotomy (4/12) and extensive adhesiolysis (2/12). The non-operative reasons for admission included lack of social care (1/4), anaesthetic complications (2/4) and poor diabetic control (1/4).

Conclusion: In our study the unplanned admission rate was 9.4%. There are very few published standards for unplanned admission rates. The Royal College of Anaesthetists have suggested a less than 2%[1] unplanned admission rate. In this study we found very few modifiable factors and therefore we would like to publish our performance as a benchmark for a gynaecological day case unit in a tertiary hospital setting.

References:

1. *Raising the Standard: A Compendium of Audit Recipes* 3rd Edition (2012). The Royal College of Anaesthetists.

P5 A Service Improvement Project: Moving From Intraoperative Intravenous To Preoperative Oral Simple Analgesics In Day Surgery

Kim Wild[2], Wasim Huda[1], Shilpa Pangam[1]

[1]West Suffolk Hospital, Bury St. Edmunds, UK, [2]Norfolk and Norwich University Hospital, Norwich, UK

Objectives: Day surgery guidelines state: "Prophylactic oral analgesics with long-acting NSAIDs should be given to all patients if not contraindicated".

Historical practice at the West Suffolk Hospital was to administer simple IV analgesia intraoperatively. We introduced a service improvement project to move to preoperative oral simple analgesia in adult patients.

Method: An audit of 50 DSU laparoscopic cholecystectomies (8/2014 - 11/2014) found that 4% received preoperative oral paracetamol 1g. All other analgesics were given IV intraoperatively.

We calculated that the WSH spent ~£1547 on paracetamol and ~£7144 on NSAIDs over one year (03/2014 - 02/2015). Moving to oral preoperative analgesics would reduce costs by 94%. Consequently, we introduced a preoperative oral analgesia pathway in October 2015, whereby patients were administered preoperative paracetamol and ibuprofen retard if appropriate. We audited analgesic practice in 150 day surgery patients, analysing: preoperative analgesia use, postoperative pain scores, rescue analgesia use, and time in recovery.

Results: Regarding preoperative analgesics: 32% (48) of patients had no preoperative analgesics, 9 % (14) had paracetamol, and 59% (88) had both paracetamol and ibuprofen.

Postoperative median pain scores in recovery were: 2/10 (IQR 0-5) for patients given no preoperative analgesia, 1.5/10 (IQR 0-5) if given paracetamol preoperatively only, and 0/10 (IQR 0-4) if given both paracetamol and ibuprofen. There was no statistical difference between groups.

There were no complications with patients given ibuprofen in the fasted state.

Conclusion: Preoperative oral simple analgesics are effective for acute postoperative pain. Our initial data potentially suggests a trend towards lower median pain scores with both paracetamol and ibuprofen, but requires larger numbers of patients for adequate power. Converting to preoperative oral analgesics saves money and reduces our carbon footprint.

References:

1. Verma R, Alladi R, Jackson I, et al. Day case and short stay surgery: *Anaesthesia* 2011; 66:417–434.

P6 Theatre Cancellations Reduction Project: Reducing Elective Urology Surgery Cancellations From Urinary Tract Infections

Kim Wild, Anna Lipp, Stuart Irving, Sue Hull, Beverley Williams

Norfolk and Norwich University Hospital, Norwich, UK

Objectives: The Norfolk and Norwich University Hospital (NNUH) has a busy elective day surgery programme. However, endourological surgery (involving: stent placement, or rigid or flexible ureteroscopy), has a cancellation rate secondary to a urinary tract infection (UTI), of 5–6 cases per month. European urology (EAU) guidelines advise that UTIs must be treated pre-surgery. We aim to reduce cancellations by >50%.

Method: We focused on patients undergoing elective: ureteroscopy, or stent procedures. We excluded: non-urological or emergency surgery, and paediatric patients.

Our protocol involves the patient independently taking a midstream specimen of urine (MSU) at home. We provide a kit including: a pre-labelled MSU pot and request form, with clear instructions on how to perform a MSU. Two weeks preoperatively, the patient carries out their MSU, and delivers the sample to their local GP surgery to send for regional microbiology analysis. The urology specialist nurse reviews the MSU results, and if positive, contacts both the GP and patient to start treatment with the appropriate preoperative antibiotics. On admission, if the patient has urinary symptoms, their urine is dipsticked.

The NNUH employs ORSOS (Operating Room Scheduling Office System), which collects data on cancellation rates.

Results: We introduced the pathway in February 2016, and will have preliminary results shortly. We are collating the number of patients asked to perform preoperative MSUs, and will analyse how many were diagnostic of a UTI, whether these patients had preoperative antibiotics, and if they were cancelled on the day of surgery.

Conclusion: Reducing theatre cancellations improves efficiency and improves patient care. We have recently introduced our protocol and plan to review our progress.

References:

Türk C, Knoll T, Petrik A et al. Guidelines on urolithiasis. European Association of Urology. 2015. Retrieved from http://uroweb.org/wp-content/uploads/22-Urolithiasis_LR_full.pdf. (Accessed 16/10/2015).

P7 Risks Of Day Surgery Discharge Criteria – Polydipsia Induced Hyponatraemia Following Day Surgery, A Case Report

Rama Varadan[2], Prasad Lanka[1], Narendra Pai[1], Sudhakar Srirama[1]

[1]Hull & East Yorkshire NHS Trust, Hull,East Yorkshire, UK, [2]Scunthorpe General Hospital, North Lincolnshire, UK

Objectives: Hyponatraemia is the most commonly encountered electrolyte disorder[1]. Ignorance of effects of hyponatraemia after surgery can cause substantial mortality & morbidity. We report a case of iatrogenic hypotonic hyponatraemia following day surgery.

Methods: 78 year old male underwent day case elective laparoscopic inguinal hernia repair. Pre-operative investigations were normal. Intraoperative period was uneventful. Postoperatively as he had not passed any urine, he was asked by the nurse to drink fluids to encourage micturation to meet discharge criteria. He drank 5 litres of water in the next 3 hours. 14 hours later patient had low GCS & seizure. Investigations showed sodium of 115 meql/l, urine sodium <15 meq/l & osmolality 71 mosm/l. He was treated appropriately with endocrinology input in intensive care with diuretics,fluid restriction & hypertonic saline.

Conclusion: Clinical conditions that result in water intoxication include psychogenic polydipsia[2] pregnancy, alcoholism, tumours, child abuse & transurethral resection of prostate syndrome. To our knowledge we report the first case due to patient's effort to meet discharge criteria. The maximum amount of water a person with normal renal function can drink is 0.8-1L/hr to avoid hyponatraemia. Severe hyponatraemia with serum sodium <120 meq/l can cause seizures or coma2 due to osmotic disequilibrium. Clinicians often fail to recognise risks of hyponatraemia, disregard the risks of infusions of hypotonic fluids,confuse early symtoms of hyponatraemia with postoperative sequelae & attribute the serious neurological symptoms of hyponatraemic encephalopathy to other conditions such as stroke[3].Early detection, expeditious treatment & close monitoring of rate of correction of serum sodium are crucial in preventing fatal complications like pontine myelinolysis.

References:

1. Verbalis JG et al, Hyponatremia treatment guidelines 2007: expert panel recommendations. *Am J Med* 2007;120:S1–21.
2. D.J.Farrell et al Fatal Water intoxication *J Clin Pathol*. 2003; 56:803–804.
3. N.Lane et al Hyponatraemia after orthopaedic surgery *BMJ* 1999;318;1363–1364.

P8 Surgery, Travel And Deep Vein Thrombosis; Are The Guidelines Being Met?

Yvette Redpath[1,2], Samuel Wood[1,2], Rachel Morris[1,2]

[1]Norfolk and Norwich University Hospital, Norwich, UK [2]Norwich Medical School, Norwich, UK

Objectives: This audit assessed adherence to the Norfolk and Norwich University Hospital (NNUH) guidelines surrounding venous thromboembolism (VTE) prevention in travel and surgery[1]. Patient awareness of risk and prevention of VTE with travel and surgery was also assessed.

Method: Patients attending the NNUH for surgery under general anaesthetic were interviewed. Patient pre and post-operative travel plans were requested, whether they'd received an information leaflet about VTE risk or seen the VTE and travel posters around the hospital. Pre-operative assessment notes were also reviewed to see if patient travel plans had been documented, and how these compared to the interview responses.

Results: 25 patients were interviewed. 88% denied a journey of >6 hours in the 6 weeks pre-operatively, and 96% denied planning a journey of >6 hours in the 6 weeks post-operatively. 100% of patients' travel history had been checked and documented. 76% of patients were aware of the risks of long journeys around the time of surgery, 36% had noticed the VTE travel posters and 84% had received an information leaflet.

Conclusion: All patients' travel plans had been documented in the pre-op notes, meeting the pre-established standards expected. However 12% of patients, reported a journey of greater than 6 hours in the 6 weeks prior to their surgery. This indicates that patient travel plans are changing between the time of pre-op clinic documentation and the day of surgery, or that patients are reluctant to truly reveal their travel plans.

Though few patients had noticed the travel posters, the majority were aware of the risks of travel around surgery. It is necessary to consider whether the posters are an effective means of communicating this risk, and perhaps the information leaflet is a more successful means.

References:

1. Morris R, et al. Surgery, travel and Deep Vein Thrombosis (DVT). *NNUH Guidelines*. 2015

P9 Patient Experience Of Post-Operative Nausea And Vomiting (PONV) And Pain In Day Case Surgery – A Single Centre Telephone Audit

James Wu[1], Thomas Gately[1], Ayda Borjian Boroojeny[2], Helen Goddard[1], Rachel Morris[1]

[1]Norfolk and Norwich University Hospitals, Norwich, UK [2]UEA Medical School, Norwich, UK

Objectives: To ascertain the incidence of pain and PONV in our day case surgery patient population.

Method: Consent for the audit was obtained from 100 day case patients over seven non-consecutive days. These patients were contacted one day after their operation regarding their experiences, pain score, and presence of nausea and vomiting. Their access to analgesia and anti-emetics were noted. Patient notes and perioperative records were reviewed to determine the Apfel score[1], anaesthetic technique used and any perioperative anti-emetics or analgesia used.

Results: 63 patients responded, with 16% (n=10) patients reporting postoperative or post-discharge nausea and vomiting. Apfel scores for the sample of patients were 0 (25%), 1 (29%), 2 (32%) and 3 (14%.) The majority of patients, 84% (n=53) received dual anti-emetics/interventions where indicated by the consensus guidelines[2]. There was no correlation between antiemetic strategies and patients who reported PONV. 5% (n=3) of patients had access to anti-emetics at home.

16% of patients reported pain rated moderate (2/3) or severe (3/3) on the Verbal Rating Scale at 24 hours post op. All of these had access to analgesia at home, as did most of the patients contacted (95%.)

Conclusion: PONV and pain are both debilitating complications with severe symptoms being associated with considerable morbidity1. Here we examined local practice and found significant incidence of both symptoms appearing in post discharge patients despite using appropriate scoring systems and interventions. This suggests that there are likely to be patient factors involved and emphasises the importance of clinician's judgement over a reliance on strict adherence to guidelines. There is also much wider availability of analgesia at home compared to access to anti-emetics, and we wonder if there needs to be a more liberal prescription of anti-emetics at discharge.

References:

1. Apfel et al. *Anesthesiology* 2012;117:475–86.

2. Gan et al. *Anesth Analg* 2014;118:85–113.

P10 An Audit Of Theatre Cancellations In A District General Hospital

Andrew Birch, Eftychia Sousi, Elaine DeSilva

Barking Havering and Redbridge University Hospitals NHS Trusts, Romford, Essex, UK

Objectives: Cancellations on the day of operations lead to a significant financial loss for NHS trusts and have a negative psychological impact on patients1. This study aimed to identify avoidable cancellations related to inadequate patient anaesthetic pre-assesment and optimisation in clinic in order to improve theatre utilization and efficiency.

Method: We retrospectively reviewed the notes of 100 patients, (35 non-elective, 65 elective) who had been subject to a cancellation on the day of surgery, coded on Phoenix as 'patient unfit' or 'patient needs further investigations' at BHRUT NHS Trust between 08/2014 and 01/2015. Furthermore, we tried to determine whether the cancellations were avoidable, adherent to clinical guidelines (where present), and whether the coding was correct.

Results: 38% of cases were inappropriately coded. Overall, 36% of cancellations were potentially avoidable, 42% were unavoidable, while 22% were insufficiently documented and therefore impossible to assess. No departmental guidelines regarding cancellation criteria for common conditions such as hypertension and diabetes exist at our trust. Approximately 12% of cancellations could have been avoided with an efficient anaesthetic pre-assessment service.

A lack of follow-up of abnormal results/ issues identified in surgical or anaesthetic clinic prior to the day of surgery was noted. Common reasons for avoidable cancellations on the emergency list include patients being booked before senior review, lack of early identification of easily reversible issues and late anaesthetic review.

Conclusion:

Our recommendations include:

1) Introduction of a database of issues flagged up in anaesthetic clinic, with a plan, review date and criteria for surgery

2) Introduction of a cancellation sticker for compulsory anaesthetist and surgeon documention in notes to guide coding.

3) Trial of a pre-assessment 'virtual clinic' to review all pending issues/results.

4) Clarify departmental guidelines for management and cancellation criteria for hypertension, diabetes etc.

References:

1. Dell'Atti L, *Urologia* 2014; 81 (4); 242–5.

P11 Daycase Laparoscopic Cholecystectomy (LC), Can We Increase The Rate Of Daycase LC At A District General Hospital (DGH) In Egypt?

Mohamed Maatouk[1], Gehad Hamada[2], Amr Askar[2], Ahmed Aboghoneem[2]

[1]Kafr Eldawar General Hospital, Kafr Eldawar, Egypt, [2]Alalamin General Hospital, Alalamin, Egypt

Objectives: To evaluate the feasibility and safety of ambulatory laparoscopic cholecystectomy (LC) in a small district general hospital and to study the reasons for unplanned overnight stay (LC).

Method: Data were collected prospectively and consecutively for planned day case LC patients from March 2015 to March2016 in Kafr Eldawar general hospital in Egypt. Outcomes were analyzed for patient demographics, operation time, blood loss during operation and frequency and reasons for unexpected overnight hospitalization.

LC was performed on 56 consecutive patients at our hospital in this period. We included all patients who underwent LC, the exclusion criteria were previous upper abdominal surgery; living alone; ASA 4 and living more than one hour away from hospital. All operations were performed on the morning list to ensure proper postoperative recovery time prior to discharge. All patients underwent LC using a standard four ports and open Hasson's technique. The postoperative pain control regime was standardized.

Results: A total of 56 Patient underwent LC with a plan for daycase surgery, all cases were done in the morning lists, there was no conversion to open cholecystectomy, no hospital mortality and no patient was readmitted with serious morbidity after discharge. We followed the guidelines for the daycase discharges. A total of 53 patients had a daycase LC and 3patient had an unexpected overnight stay LC.

Conclusion: Day case LC can be performed in developing countries with a low rate of complications, we should ensure the criteria for selection of cases and discharge criteria following the procedure. LC should be done in the morning list if possible to allow adequate time before discharge.

References:

1. Verma R, Alladi R, Jackson I, et al. Day case and short stay surgery: *Anaesthesia* 2011; 66: pages 417–434.

P12 Getting Home Safely – The 'Six Steps To Safer Mobilisation' After Spinal Anaesthesia In The Day Surgery Setting

Marta Kocsor-Bell, Kris Inkpin, Amelia Banks

Nottingham University Hospital NHS Trust, Nottingham, UK

Objectives: Short acting local anaesthetic agents, such as chlorprocaine and prilocaine, are increasingly being used for spinal anaesthesia in the day surgery setting. Safe discharge after spinal anaesthesia requires restoration of normal power, proprioception and balance and the time frame for this can be unpredictable. Premature mobilisation can result in patient harm and presents a risk to staff - who may be injured if a patient falls when attempting to stand and walk. Following a patient complaint and a significant critical incident in the day surgery unit a structured assessment tool was developed to ensure safe mobilisation of patients after spinal anaesthesia – 'The Six Steps to Safer Mobilisation'.

Method: A simple, standardised assessment was produced. The test needed to be quick, reliable and comprehensive. Senior nurses were taught by a consultant anaesthetist and these staff cascaded the tool to the rest of the day surgery team. Posters explaining the tool were produced and placed in prominent locations in the day surgery unit. All patients who have had spinal anaesthesia are assessed using the tool and are only mobilised when they have successfully completed all six steps.

Results: The introduction of the 'Six Steps to Safer Mobilisation' has been welcomed by day surgery staff, who feel more confident that patients are safe prior to discharge. In the year since the tool was adopted there have been no further critical incidents and no patient complaints. The assessment tool has been extended to patients having day surgery in the urology unit.

Conclusion: Spinal anaesthesia for day surgery can offer patients many advantages but safe discharge relies upon restoration of normal power. The development and adoption of a structured mobilisation assessment tool has resulted in safer discharge of patients after spinal anaesthesia and increased patient and staff satisfaction.

P13 Audit To Assess If Patients Receive, Read And Understand Pre-Operative Anaesthesia Information Leaflets

Samuel Hewitt, Bruno Gnaneswaran, Rachel Morris
University of East Anglia, Norwich, UK

Objectives: Patient information leaflets (PIL) can play a significant role in supporting decision making and empowering patients1. It is essential to continuously thrive to improve the standard of information provided to patients in order to make informed decisions about one's healthcare. PILs play a pivotal role in this2 .

Royal College of Anaesthetists states that every patient must be fully informed about their proposed surgical anaesthesia and the estimated levels of risk involved3. The aim of this audit is to improve the understanding and sharing of pre-operative information through patient information leaflets in anaesthesia.

Method: Information was collected from 61 adult patients awaiting surgery either as a day procedure or in-patient through a structured interview in November and December 2015. Patients were selected at random from Day Procedure Unit and Same Day Admissions Unit prior to surgery.

Results: Eighty percent of patients interviewed received a PIL, with 69% of these patients reading the PIL. Out of the patients that read the PIL, 97% understood it. Ninety-seven percent of patients reported the usefulness of the information as either good or excellent. Finally, 91% of patients interviewed were satisfied with a leaflet as a medium of information.

Conclusion: We have shown that although a high proportion of patients found the information useful and understood the information on the leaflet, the number of patients who received a PIL in anaesthesia is unsatisfactory - this ratio should be 100%. More must be done in order for all patients to receive a PIL in anaesthesia.

References:

1. Lui, F et al. *International Journal of Clinical Pharmacy* 2014; 827–834.
2. Paoloni, C et al. *Anaesthesia* 2000, 55.
3. Jones K et al. *Royal College of Anaesthetists: Guidelines for the Provision of Anaesthetic Services* 2014.

P14 Identification Of 'White Coat Hypertension' In Pre-Assessment Clinic Using The Florence Simple Telehealth System

Helen Magee, Leah Frame, Nigel Bedforth
Circle Healthcare, Nottingham, UK

Objectives: Pre-existing hypertension is the most common avoidable medical reason for postponing surgery[1]. We wished to reduce unnecessary delays from pre-assessment clinic due to white coat hypertension by implementing patient-guided blood pressure (BP) monitoring.

Method: Patients with blood pressures greater than 180/100 at pre-assessment are asked to monitor their BP at home, twice daily, for one week using the Florence (Flo) simple telehealth text message service (Mediaburst Ltd. Manchester, UK). Patients consent to monitor their BP and text the results to our system. High readings are managed by the pre-assessment nurses. Limits are set locally.

Results: Since December 2015; of 17 patients with hypertension at pre-assessment, 9 were found to be actually normotensive and 5 hypertensive requiring treatment. Three are still taking part.

Conclusion: Flo allows patients to take responsibility for their own health by enabling them to independently monitor their BP. Flo can help us differentiate 'white coat' hypertension from established hypertension, thereby preventing unnecessary delay in the patient pathway and possibly unnecessary treatment.

References:

1. Dix P, et al. Survey of cancellation rate of hypertensive patients undergoing anaesthesia and elective surgery. *Br J Anaesth* 2001; 86 (6):789–93.

P15 A Critical Ethnographic Exploration Of Preoperative Pain Planning For Day Case Surgery Patients

Claire Ford

Northumbria University, Newcastle Upon Tyne, UK

Objectives: Pain is a ubiquitous sensation experienced by all, but unique and multifarious in nature1. In an attempt to reduce perioperative pain there has been a multitude of studies examining its management. However, there appears to be limited research critically examining how pain is discussed with day case patients before surgery and how pain management is integrated into the care continuum prior to surgery.

Method: In order to examine individual values and beliefs, power, culture and politics; a critical ethnographic methodological approach was adopted, utilising quantitative and qualitative methods. This included observation of daily working practices, with a focus on preoperative assessment and consultations. In addition examination of documentation and interviews with the healthcare professionals to uncover views and opinions was completed.

Results: 130 hours of practice has been observed, incorporating 100 preoperative anaesthetic visits and 24 nurse-led preoperative assessments. 20 staff were subsequently interviewed. Initial analysis of the quantitative data from the anaesthetic visits indicates that pain was discussed in 97% of cases; however, a pain plan was only documented in 7% of cases. The patient's preoperative pain was discussed in 11% of cases and the mean length of time spent discussing pain was 49.09 seconds. Within surgical specialities the mean ranged from 37.4 seconds for urology to 68.7 seconds for orthopaedics, and for anaesthetic staff ranged from 37.6 seconds for junior anaesthetists to 63.6 seconds for physician assistants.

Conclusion: Practice between anaesthetic staff is varied and the length of time spent discussing pain is wide-ranging; not only between the anaesthetic staff but also between surgery specialities. As analysis of the qualitative data is ongoing, these results will be explored further in an attempt to critically examine the culture, power and politics underpinning preoperative practices.

Reference:

1 Rejeh N, et al. *Nursing & Health Sciences* 2010; 12.1:67–73.

P16 A Systematic Literature Review Investigating The Role Of Postoperative Venous Thromboembolism Prophylaxis Following Day Surgery

Joseph Boylan

The University of Liverpool, Liverpool, Merseyside, UK

Objectives: This article systematically evaluates the literature regarding the rationale of postoperative venous thromboembolism (VTE) prophylaxis for procedures commonly performed in day surgery.

Method: A literature search was performed on CINAHL Plus, Cochrane database, Medline and Scopus to review articles from the past 10 years. The abstracts for each article were read and compared with the inclusion-exclusion criteria of this review.

Results: At least 80 studies were found relating to VTE prophylaxis and day surgery but only three articles were chosen and critically appraised. Overall there was a low incidence of postoperative VTE and anticoagulant VTE prophylaxis caused minor bleeding complications[1,2,3]. The review found no RCTs on this topic.

Conclusion: Routine postoperative VTE prophylaxis is unnecessary for most day surgery procedures as it seems to hold little benefit and causes minor harm. Nonetheless clinicians should follow current guidelines on VTE risk reduction by assessing all surgical patients' risk of VTE against their risk of bleeding.

References:

1. Lozano FS et al. *Ambulatory Surgery* 2010;16(1):5–12.
2. Hoppener MR et al. *Acta Orthopaedica* 2006;77(5):767–771.
3. Nguyen NT et al. *Ann Surg* 2007; 246:1021–1027.

P17 Is Your Hospital At Risk Of Being Accused Of Not Providing Fair And Equitable Daycase Vein Surgery To Patients? Closing The Loop

Lee Creedon, Ruth Parks, Bruce Braithwaite
Queens Medical Centre, Nottingham, UK

Objectives: In 2015 we undertook an audit to identify if our department was providing a fair and equitable service for patients suffering with varicose veins. As per Clinical Commissioning Group (CCG) guidance, patients must suffer with a significant complication of their varicose veins (Lipodermatosclerosis, skin damage, ulceration, a healed ulcer, bleeding from the vein, at least 2 episodes of thrombophlebitis or varicose eczema) to be eligible for NHS treatment. We identified that up to 28% of patients might have been ineligible for NHS funded treatment, which clearly needed to be rectified. Consultant and General Practitioner education regarding eligibility and documentation were undertaken as well as screening of referrals by a single consultant.

Method: After the first Audit, all vascular consultants were informed that there was a risk that they would have to pay for all the costs of treatment themselves should the Trust and the commissioners identify a patient had been offered treatment outwith the criteria. A re-audit was done of patients who had surgery 3 months after the warning had been given. All patients who had daycase varicose vein surgery at a single centre between August 2015 and January 2016 inclusive were identified. Electronic clinic letters and operation notes were scrutinised for documentation of eligibility.

Results: 192 patients were identified as having undergone varicose vein surgery. 85.9% of patients had documented eligibility criteria in electronic clinic letters and a further 2.1% within operation notes, giving a total of 88% documented eligibility vs 72% in 2015.

Conclusion: We have identified an early improvement in concordance with CCG guidance. However we have yet to achieve our audit standard of 100%. Invoices have been sent to the respective consultants to demonstrate how much they would owe the Trust in lost income should the CCG enforce their criteria.

P18 It's An Ill Wind . . . An Audit Of Perioperative Hypothermia

Kelly-Marie Clarke, Susan Bowler, John Vernon
Nottingham University Hospital, Nottingham, UK

Objectives: An audit assessing our compliance with 2008 NICE Guidelines on Perioperative Hypothermia1 was performed. A stimulus for this was staff noticing that the Heating system was erratic, recovery felt colder than other areas, with staff sometimes needing to wear jackets there.

Method: Following Trust Audit registration, in March 2014 the following data was recorded in 130 patients: Admission temperature to Day Surgery Unit (DSU), admission temperature to recovery, time on operating table, perioperative warming equipment used, time in recovery. (Temperatures by tympanic membrane thermometer.)

Interventions following data analysis: Purchase several thermometers to measure waiting area, theatre, recovery, ward temperatures. Discussion with Hospital Maintainance to adjust heating plant giving higher more stable temperatures in DSU, with 'hotline' for temperature adjustment. Information instructing patients to keep warm before arriving in DSU. Use of forced air warmers encouraged. Immediate feedback to theatre of any hypothermic patients. 'Star chart' in recovery recording each patient temperature. Significant 'wind chill' in recovery due to unmodifiable air vents in ceiling over patients identified as problem. Warmed blankets available and patient's skin not exposed in recovery.

Results: 88% and 57% of patients had core temperature of <36C on arrival in DSU, and recovery respectively. Only 25% of patients actively warmed in theatre.

Informal evaluation of post-op patient temperature in recovery showed a large improvement. This will shortly be formally re-audited. Following the changes staff comfort was much improved.

Conclusion: In our unit we identified a significant incidence of perioperative hypothermia. We have instigated several interventions throughout the patient journey to prevent patient hypothermia. This has also resulted in a significant improvement in staff wellbeing.

References:

1. National Institute for Health and Clinical Excellence. 2008. Inadvertent perioperative hypothermia: The management of inadvertent perioperative hypothermia in adults. CG 65. London: National Institute for Health and Clinical Excellence.

P19 Successful Delivery Of Bilateral Mammoplasty In The Daycase Setting

Hilary Brewer, Puja Chhaniyara, John Vernon, Eleanor Gutteridge

Nottingham Breast Institute, Nottingham, UK

Objectives: The vast majority of breast operations can be safely performed as daycase procedures, including Bilateral Mammoplasty (BM) 1. However at a large teaching hospital, there was a perception that admission of daycase BM patients was a frequent occurrence.

Method: Data of BM procedures performed between January 2012 and December 2013 in the day surgery unit were analysed for: anaesthetic start time, total procedure duration and hospital admission. Data was extracted from the "intended operation" recorded in the electronic operative theatre management booking system.

After initial analysis revealed delayed start and protracted operative times to be possible causes of admission, guidance was issued that BM patients should either be first on the list or start before 11am and should be operated on by a senior surgeon to facilitate a duration of less than 3 hours. Re-audit was undertaken for January 2014 to December 2015.

Results:

- 21 BMs performed 2012-13: 5/21 admitted (24%), 17/21 (81%) started after 11am, 6/21(29%) after 1pm and 5 /21 (24%) operations were >3 hours.
- 19 BMs performed 2014-15: 1/19 admitted (5%), 12/19 (63%) started after 11am, 4/19 (21%) after 1pm and 5/19 (19%) operations were > 3 hours.

Conclusion: Admission rate decreased from 24% to 5%. Despite producing guidance to optimise patient management, these plans were difficult to implement due to the logistics of liaising with other departments eg, nuclear medicine/ radiology. The difference in admission rate may reflect the learning curve associated with introducing a new procedure to a daycase unit. The critical factors for successful delivery in the day case setting are experienced pre operative surgical selection/assessment, excellent perioperative nursing care and expert anaesthetic management.

References:

1. Delivering major breast surgery safely as a day case or one night stay www.nhsiq.nhs.uk/8237.aspx#sthash.yaWAh1Nj.dpuf

P20 Does High BMI Affect The Outcome Of Day Case Laparoscopic Cholecystectomy?

Hayley Comer, Hannah Ferrington, Kanagaraj Marimuthu, Chaminda Sellahewa

Russells Hall Hospital, Dudley, UK

Objectives: The purpose of this study was to investigate any association between Laparoscopic Cholecystectomy and adverse outcomes in high BMI patients at a District General Hospital.

Method: This is retrospective data of day case cholecystectomies performed by a single surgeon between April 2011 and October 2015. The primary outcome was Length of Hospital Stay (LOHS) and secondary outcomes collected were readmission due to pain, bleeding, intra-abdominal collection, port-site infection, bile leak, damage to bile ducts and bowel.

Results: 873 consecutive cholecystectomies were analysed, 216 (24.7%) Patients were male and 657 (75.3%) were female. Results showed that there was no statistical difference in LOS between patients with a Normal BMI (0.46 days), patients with Obese BMI Class I and II (0.42 days) and patients in Obese BMI Class III (0.54 days). Conversion from laparoscopic cholecystectomy to open cholecystectomy was needed in 2.7% (24) of all patients, 3.1% of patients with a normal BMI, 2.3% of patients in Obese BMI Class I and II, and 0.9% of patients in Obese BMI Class III. Overall complication rate for all patients was 6.4%, 4.6% for patients with a normal BMI, 7.1% for patients in Obese BMI Class I and II, and 6.4% of patients in Obese BMI Class III.

Conclusion: Laparoscopic cholecystectomy is a safe procedure for all patients independent of BMI and is not associated with increased LOS.

References:

HPB (Oxford). 2015 Jul;17(7):600-4. doi: 10.1111/hpb.12415. Epub 2015 Apr 23.Safety and efficacy of a laparoscopic cholecystectomy in the morbid and super obese patients.Tiong L1, Oh J1.

Surg Endosc. 2012 Apr;26(4):964-9. doi: 10.1007/s00464-011-1978-5. Epub 2011 Oct 20.The impact of body mass index on outcomes after laparoscopic cholecystectomy.Farkas DT1,

J Surg Res. 2014 Aug;190(2):491-7. doi: 10.1016/j.jss.2014.02.014. Epub 2014 Feb 15.Obesity does not increase morbidity of laparoscopic cholecystectomy.

P21 Preoperative Hydration Programme: A Quality Improvement Project At A Tertiary Orthopaedic Referral Centre. Royal Orthopaedic Hospital, Birmingham

Kuda Nyangoni, Abiola Ladele, Egidio Da Silva

Royal Orthopaedic Hospital, Birmingham, UK

Objectives: Advantages of optimal fluid fast time/therapy is well elucidated. The ESA/RCOA recommend a safe intake of free fluid up to 2hrs before surgery[1]. Dehydration and consequent hypovolaemia in high-risk surgical patients undergoing major surgery increases the incidence of perioperative and post-operative complications.

The ROH, is a stand-alone tertiary referral centre for complex orthopaedic oncology, spinal and arthroplasty surgery with an output of ~9000 daycases/year, many with major co-morbidities. Patients are often admitted in the morning with many surgeries taking place in the afternoon.

In our institution, patients were still receiving outdated instructions resulting in prolonged fasting, in particular, free fluid with associated increased risk of poor patient outcome and experience.

We instituted a water intervention aimed at all elective patients encouraging water intake up to 2 hours before surgery.

Method: Patients and staff education leaflets and posters with explicit fasting times (up to 1hr water fast time before admission) were designed and displayed in admissions and daycase unit (ADCU), and outpatients' departments.

Following theatre team brief, all patients with minimum of 2hrs prior to commencement of their surgery were issued "water prescription" by anaesthetists.

The ADCU coordinating nurse implements the water prescription to facilitate compliance and safeguards the operating list.

This continued intervention commenced in Feb 2015, is audited regularly.

Results: The primary outcome measurement was the fluid fast time. Results show a decreasing trend in the fluid fasting times with a mean reduction from 10 hours in Dec 2010 to 3 hours in October 2015.

Conclusion: Improved compliance was notably a product of better patient and staff education; the institution of an ADCU coordinating nurse with improved communications between ADCU and theatres; and a fostering of a corporate ownership of the water fasting time from ADCU nurses to theatre staff.

Reference

1. Smith I et al. *Euro J Anaesthesiol* 2011;28(8):556–569.

P22 A Complex Pathway To Day Surgery

Rachel Tibble, Pam Clarke, Mary O'Halloran Brown, Wendy Holmes-Taylor

Royal Derby Hospital, Derbyshire, UK

Objectives: Pre-operative assessment is paramount for safe and efficient day surgery. In our unit we aim to offer day surgery to every patient where possible. Here we present a case study where a very complex patient was managed through pre-operative assessment collaboration with other specialties to achieve a successful result for day surgery.

Method: A 54 year old man presented for day surgery mastoid exploration. We review his progress through the day surgery pathway from pre-operative assessment to successful day surgery to document the co-ordination and communication roles of pre-operative assessment staff.

Results: At pre-operative assessment he had a history of obstructive sleep apnoea with previous CPAP treatment, was HIV positive, on antiretrovirals only 1 week and hypertensive on no treatment. His airway was predicted as difficult.

Severe obstructive sleep apnoea was confirmed and sleep physician review organised to restart CPAP treatment pre-operatively.

In conjunction with the HIV specialists we monitored his viral load, which started at 67,000 and reduced to 3000 using Truvada™ and Darunavir. A final reduction to safe levels was achieved by adding Ritonavir. CD4 levels were >350.

The GP started antihypertensives.

Pre-operative nurses kept the patient informed of progress and, after discussion with surgeons and anaesthetist, a date planned. The patient was last on the list with precautions for staff highlighted.

Despite a difficult intubation and 2.5 hours operating, the patient recovered and was able to go home the same day, using the CPAP machine at home.

Conclusion: Patients with multiple co-morbidities may seem difficult as day surgery patients but we have shown through meticulous pre-operative assessment and continued communication with different specialties that this can still be managed and the patient go home the same day.

Permission granted from the patient for use of this information.

P23 Laparoscopic Cholecystectomy : Can It Be Too Complex To Be A Day Case?

Nichola Coleman[1], Parminder Kaur[1], Mangta Manu[1], Madhu Ahuja[2]

[1]Department of Upper GI Surgery, Royal Wolverhampton NHS Trust, West Midlands, UK [2]Department of Anaesthesia, Royal Wolverhampton NHS Trust, West Midlands, UK

Objectives: Day case surgery is the mainstay option for treatment of gallstone disease. However, there is still on-going concerns and debate as to which patients will benefit from this service.

Method: We describe the case of a laparoscopic cholecystectomy under taken as a day case highlighting successful outcome can be achieved in patients who have had previous complex intra-abdominal surgery.

Results: LJ developed symptomatic gallstone disease requiring a cholecystectomy. With a background of an open total colectomy, ileoanal pouch and loop ileostomy formation, with subsequent reversal for Ulcerative Colitis the recommended procedure of a laparoscopic cholecystectomy had an increased risk of conversion to open surgery and prolonged stay in hospital. The patient was listed as a day case procedure with a provisionally overnight bed booked.

The patient was listed first on a morning list to allow time for recovery. The patient had total intravenous anaesthesia with pre-emptive analgesia and intra-operative prophylactic anti-emetics. Due to her previous laparotomy the usual method of achieving pneumoperitoneum through an infraumbilical incision was modified to an open Hassan technique in the right upper quadrant. A 12mm port was inserted to create a pneumoperitoneum of 12mmHg. At laparoscopy, adhesions between the omentum and the anterior abdominal wall along the length of her laparotomy incision were divided, 2 further 10mm ports and a 5mm port were placed under direct vision and the cholecystectomy was performed without incident.

LJ made an uneventful post-operative recovery and was discharged home the same day.

Conclusion: By modifying surgical techniques, careful planning on timing and anaesthesia suitable for day case, laparoscopic cholecystectomies can be performed as a day case on patients with previous complex intra-abdominal surgery with good outcomes.

References:

Tenconi S et al *International Journal of Surgery* 2008; 6;(1); S86–88.

Weibel M et al *American Journal of Surgery* 1973;126(3):345–353.

P24 How Does Service Design Affect Rates Of Day Case Surgery For Hyperparathyroidism?

J Thomas, WD Jones, M Oliver, DM Scott-Coombes, MJ Stechman

University Hospital of Wales, Cardiff, UK

Objectives: Parathyroidectomy for primary hyperparathyroidism (pHPT) may be performed on a 23 hour basis but pre-operative localisation may allow a less invasive focussed procedure to be performed as a day case. The objective of this study was to examine whether the time of day of surgery affects the chances of completing day case parathyroidectomy.

Method: In October 2013 a weekly parathyroid list was moved from an afternoon to a morning session, whilst anaesthetic and surgical personnel remained the same. A prospectively maintained database on patient demographics, disease severity, procedure type, length of stay and readmissions was analysed for differences before and after this change. Patients undergoing concurrent thyroid surgery were excluded (n=10).

Results: 200 consecutive parathyroidectomies (100 PM operations and 100 AM operations) were analysed. The two groups with similar with respect to: gender, median age, preoperative serum Calcium and PTH, % with multiple gland disease, and % undergoing successful localisation with neck ultrasound and sestaMIBI scan. Day case surgery was completed in 5% of PM and 35% of AM parathyroidectomies ($P<0.0005$, Chi-squared test). All patients discharged on the day of surgery from the PM group had undergone focussed/minimally invasive parathyroidectomy whereas in the AM group although the majority (25/35) had undergone focussed surgery, 10/35 had undergone bilateral exploration. There were no documented readmissions following discharge, prior to, or following the change.

Conclusion: Anaesthetic and surgical techniques alone cannot always determine whether successful day case surgery is completed. In the case of parathyroidectomy, scheduling surgery for a morning session rather than the afternoon can increase day-case rates considerably, including those requiring bilateral neck exploration.

P25 Service Evaluation On Day Case Laparoscopic Cholecystectomy

Arivaz Govindarajan, Modhar Mahmoud, Kimarnie Kydd

Kings Mill hospital, Nottingamshire, UK

Objectives: 60% of all elective laparoscopic cholecystectomies (LC) should be done as a day case[1]. The discharge rate for LC patients at Kings Mill hospital was 50.8% in 2014. We present the evaluation of our service to improve same day discharge rate and to identify the peri operative reasons[2] that led to delay in meeting the day case discharge criteria in LC.

Method: A retrospective analysis of data covering a 6-week period (April -May 2015). Data collected from all patients who had elective LC included: surgical, anaesthetic, patient and other risk factors that led to unsuccessful same day discharge (SDD).

Results: Data from 44 patients were evaluated. 32% of LC patients had unplanned admission (UA). The reasons are: Surgical 43% (drains, open surgery, difficult surgery). Anaesthetics 14%. Patient factors 22% (co morbidities, post operative cardiovascular instability). Others 21% (social and none documented reasons).

Comparing some of the peri operative factors between patients who had SDD and UA. The results are: mean of duration of surgery (64 min SDD vs. 83 min UA), the presence of drains (3.4% SDD vs. 100% UA), late finish of surgery after 4 pm (40% SDD vs. 60% UA). Only one patient stayed overnight due to nausea and vomiting and none stayed overnight due to pain. Duration of surgery, late finish of surgery and the presence of drains were the modifiable risk factors for unsuccessful same day discharge.

Conclusion: Our day case discharge rate for Laparoscopic Cholecystectomies during the sample period was within target (68%). Duration of surgery, review of drains within 6 hours and a better list scheduling to avoid late finish were reinforced to our surgical colleagues.

References:

1 BADS. *Directory of Procedures* 2009.

2 Psaila etal. *World J Surgery* 2008; 32,76–81.

P26 Implementation Of A Non-Elective Trauma List In A Stand Alone Day Surgery Unit

Shilpa Pangam, Jonathan Nicholson, Kelly Overton

West Suffolk Hospital NHS Trust, Bury St Edmunds, UK

Objectives: Emergency day surgery trauma is becoming a popular concept in view of shortage of inpatient beds, cost benefit and patient experience.[1] Implementation of a day surgery trauma list had been attempted several years ago in our hospital with limited success. A 3 month audit conducted by orthopaedic department in May 2015 highlighted the need for a day surgery trauma list. A rigorous process was set up to book patients from an emergency pathway who require surgery and also fulfilled our day case patient criteria but for whom it was safe to wait for over 24 hours before going to theatre.

Method: We performed retrospective audit of the cases undertaken on the day surgery trauma list over a 7-month period. We analysed the pre-operative assessment, case mix, and readmission rate.

Results: A total of 57 day surgery trauma cases were performed (25 lists, 4 unfilled lists). 41 (72%) assessments were performed by telephone. 1 patient required transfer to the main hospital, and 1 patient was re-admitted to the main hospital following discharge home.

Conclusion: We feel that our process has been successful in terms of pre-assessment, low transfer and readmission rate and maintaining appropriate trauma case-mix. We think a definite date and time of operation reduced the unnecessary wait and anxiety in our patients.[2] This process also benefited our trust as there was reduced demand for in patient beds.

References:

1. T Colegate-Stone et al. Audit of trauma case load suitable for a day surgery trauma list and cost analysis. *The Surgeon* 9(2011) 241–244.
2. British Association of Day Surgery. Day case surgery (2012). *Emergency day case surgery* 288–291.

P27 Day Case Cancellations In A District General Hospital

Sachin Valap, Mohammed Elreidy, Fatima Eltinay

Burton Hospital, Burton upon Trent, UK

Objectives: Cancellation of patient surgery on the day of surgery has significant implications which include loss of revenue to the hospital and disruption of patient program and needs a detailed analysis in order to introduce corrective measures to reduce them.

Method: Data was obtained from our day surgery patient data base. We looked at the speciality, reasons for cancellation-in particular anaesthetic cancellations and identified common recurring themes. These include hypertension, diabetes and cardiac diseases. We followed the audit with a survey within the departments. The survey was in the form of 5 case scenarios, tackling different common chronic health problems. For each case the questions were whether to proceed with surgery or not and if not, how patient will be optimised.

Results: Total number of patients booked were 5799, with 392 cancellations (6.75%). The 2 main reasons for cancellations were cancellation by surgeon 37% and patient not attending 29%. Cancellation by anaesthetist represented very small percentage 5% with total number of 20. By analysing these, we found hypertension to be the most common cause of cancellation (4 patients). The survey showed a lack of consensus regarding proceeding with surgery and measures needed for optimisation.

Conclusion: Despite the low percentage of cancellations by anaesthetist, there's a lack of consensus among senior anaesthetist regarding common chronic health problems and the associated risks. With the lack of local guidelines, cancellations are inevitable as it'll depend on individual decisions. We demonstrated the importance of developing preoperative local guidelines to prevent such late cancellations.

References:

1. Sear JW. Hypertension in the Preoperative Patient – Who should we cancel? National Scientific Congress of the Australian Society of Anaesthetists, 5–8 September 2009.
2. Casadei B, Abuzeid H. Is there a strong rationale for deferring elective surgery in patients with poorly controlled hypertension? Journal of Hypertension. 2005 Jan;23(1):19–22.

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